opening made, of the biliary and pancreatic fluids; such means being the maintenance of the dorsal decubitus during digestion, and, if necessary, the use of a cup or India-rubber bag to catch the escaping liquids which can later be returned into the bowel. In opening the small intestine, the following procedure is recommended:—

On a line about a third of an inch internal to the anterior extremity of the ninth rib of the left side, a vertical incision from 2 to 2¼ inches long is to be made in such a manner as that its central point shall correspond to the ninth rib. The skin, the superficial fascia, the external oblique, the internal oblique, and the transversalis muscles, and the transversalis fascia, are to be successively divided, and the peritoneum opened, with the usual precautions. The omentum being turned out of the way, and "the intestinal mass uncovered, the transverse colon, which is at the upper end of the incision, may be easily recognized, and very readily distinguished by its direction, by its colour, whiter than that of the small intestine, by its bands and constrictions, and, finally, by its relations with the omentum. Immediately below are the aggregated coils of the small intestine. Between these coils and the transverse colon, the index finger is to be carried directly down and pushed on until it meets the spinal column. The left extremity of the pancreas can then be felt, and immediately to the left of this extremity and, as it were, connected with it, an intestine, the direction of which is transverse. This intestine is to be hooked up with the curved index finger and drawn out. If it be perceived that it yields on one side, but remains firmly attached on the other, it is the jejunum at its origin. If, on the contrary, it can be equally well drawn up on both sides, it is a part of the canal further down, and must be let go, in order to search again. Most usually we come after the first stroke (*coup*) upon the part sought for, but if we fail it is not difficult, nor does it require any great length of time, to find it. Once seized, it is to be brought up between the lips of the wound in the skin and fixed there by a sufficient number of points of the interrupted suture. This done, the intestine can be opened and appropriate alimentary substances introduced." The author in a foot-note says that he has selected the first part of the jejunum in which to make the opening, because it can be easily found by following the method indicated; while, if the incision be made in any other part of the abdominal wall, we have no certain means of knowing what part of the small intestine has been opened. Enterostomy then, being in a surgical point of view an operation perfectly according to rule, and physiologically considered a rational one, should, according to M. Surmay, be regarded as the proper one in those cases in which there is no cachexia nor hemorrhage, no threatened perforation nor peritonitis, where the real cause of the impending death is inanition consequent upon impassable constriction of the pylorus, or, the pylorus being open, upon absolutely uncontrollable vomitings due to nervous disturbance or even to simple ulceration of the gastric mucous membrane. Though enterostomy has never been performed upon the living human subject, and will remain an operation of altogether exceptional rarity, M. Surmay hopes that he has done something useful if he has been able to show that it is rational, easy of execution, and, to all appearances, capable of practical application.—*London Med. Record*, August 15, 1878.

Foreign Body in the Sigmoid Flexure: Successful Removal.

A rare and curious case is related by Dr. STUDSGAARD of the Communal Hospital in Copenhagen, in a recent number of the *Hospitals-Tidende*. A man, aged 35, introduced into the rectum, with the open end uppermost, a preserve-bottle nearly seven inches long, for the purpose of stopping a diarrhœa. The next morning he complained of pain in the abdomen; chloroform was given, and the bottle, which could before this be felt in the rectum, passed higher up, and he was brought to the hospital (January 10th). The bottle could be felt through the abdominal wall, lying in the middle line, with the bottom close to the horizontal ramus of the pubic bone. In the afternoon he was deeply narcotized, and posterior linear rectotomy was performed, and an attempt was made to reach the bottle, but without success. Abdominal section was therefore performed, under antiseptic precautions, in the linea alba. An incision having been carried four inches downwards from the umbilicus, a loop of intestine, apparently a portion of the sigmoid flexure, was protruded with the neck of the bottle. The bowel was then divided over the mouth of the bottle and a little way down the neck, and removal was effected slowly. The neighbouring parts were protected by sponges and compresses from the escape of fæces; and, after the bowel had been cleaned, twelve or fourteen catgut sutures were applied to it, each being, for safety, tied with three knots. The bowel having been replaced, the wound in the abdominal wall was united by eight silk sutures. The operation lasted an hour. Recovery was slow, and the prognosis was for a time doubtful in consequence of local peritonitis and the formation of abscesses, which opened partly through the incision in the abdominal wall and partly through the rectum; the patient was, however, discharged quite cured on April 16th—less than fourteen weeks after the operation. The bottle was 17 centimetres (6.8 inches) long, 5 centimetres (2 inches) in diameter at the lower end, and 3 centimetres (1.2 inches) at the upper end. In commenting on this case, Dr. Studsgaard refers to three others of a similar character; one related by Ogle, in which recovery followed spontaneous discharge of the foreign body (a stick); one by Closmadeuc, where the patient died of peritonitis, without operation; and one in which laparo-enterotomy was successfully performed in 1849 by Reali of Orvieto.—*Brit. Med. Journal*, August 3, 1878.

Treatment of Hydrocele by Incision performed Antiseptically.

Dr. GENZMER (Volkmann's *Klinischer Vörtrage*, No. 135) gives a list of sixty-nine cases treated in this way without a single fatal result, and with no excessive inflammation. The average duration of the stay of patients in the hospital was ten days. There was in but one or two cases an elevation of temperature of more than three degrees. The method is to open the sac by an incision from three to four inches in length. The testicle is then examined, and if there be cheesy orchitis the diseased portions are laid open and scraped out. The edges of the tunica are then stitched to the scrotum with catgut sutures. The testicle now appears lying at the bottom of a gaping wound. A drainage-tube is placed vertically upon the organ, and the edges of the wound are partly approximated by one or two deep silk sutures to prevent the testicle from escaping from the sac. Primary union of the walls of the sac takes place, and a slight granulating surface is left at the end of a few days to mark the site of the cut. The tube is removed usually about the fourth day, when the silk sutures are also taken out, and the dressing changed a second time at the end of a week. The wound is then dressed with benzoated cötton-batting inside of a suspension bandage, and the patient discharged.—*London Med. Record*, Aug. 15, 1878.

Ergotin in Diseases of the Bladder.

Dr. MOLFESE, in the *Cirillo* of May 5, 1878, calls attention to the results of the internal use of ergotin in cases of paralysis of the bladder, hemorrhage, etc. He relates three cases. In the first, a priest aged 86 was suddenly attacked with retention of urine. After this condition had lasted 36 hours, the urine was drawn